THE HISTORICAL PERSPECTIVE*

ROSEMARY STEVENS, PH.D.
University of Pennsylvania,
Philadelphia, Pennsylvania

THE discussions today convey a certain sense of deja vu. We have never had an ideal health care system, we do not have one now, and we shall not have one tomorrow. We are now going through the very interesting process of identifying and examining basic assumptions inherent in American medicine and its provision. As we struggle for some kind of temporary consensus about what is happening today, we are really talking about assumptions, motivations, and human nature.

Entrepreneurialism in health care in America is not new. Indeed, entrepreneurialism distinguishes, and always has distinguished, the American medical care system both in the profit-making and not-for-profit sectors. It was not an accident that the Massachusetts General Hospital got a subsidy from the Massachusetts legislature when it was founded. Nor that earlier the Pennsylvania Hospital had also successfully lobbied in that state. Entrepreneurialism, not only in the business sense but in terms of politicking and institutional development, even game playing, is a fact of life in the United States.

Nor is the second concern about the role of large scale organizations in medicine new: There was concern in the 19th century about physicians working in contract practice. There was concern in the 1920s through at least the 1940s about what was then called the corporate practice of medicine by hospitals and by large group practices. There was some concern, with the advent of Blue Cross and other insurance schemes, about the entrepreneurial potential of the third party, the first and second parties, of course, being doctor and patient. We have, in short, a long history of considering the role of organizational structures in medicine.

I do not want to say that the more things change, nothing changes. We are currently in a very interesting period of change in at least four respects. One demand of the new entrepreneurialism is the need to rethink the nature of professionalism in medicine, not just in medicine as a profession, but in

*Presented in a panel, Implications: Who Will Benefit? as part of the 1984 Annual Health Conference, *The New Entrepreneurialism In Health Care*, held by the Committee on Medicine in Society of the New York Academy of Medicine May 3 and 4, 1984.

all the health care occupations. If medicine is a service industry, are physicians, nurses, and others to be seen as entrepreneurs, proprietors, or employees as a primary function of their role—and, if so, what does this do to the notion of professions? A second notable set of changes has been in the environment of medicine within the last two decades. I speak of the tendency within health politics and policy to stress individual over collective interests. The shift in language from the 1960s to the 1980s—from equal access to care in "mainstream" medicine to conservatism within a competitive system—has fed into entrepreneurial behavior. A third change is that investor ownership and large scale systems have brought absentee landlords onto the scene, challenging the notion of health care as a community responsibility. The fourth, and perhaps most interesting recent development, is the rise of new groups involved in medicine, in lobbying, and in policy making: from self-help groups to business coalitions. I call this phenomenon the rise of fourth parties.

The point remains, however, that change takes place within long-established structures, builds on old assumptions and needs to be seen in long-term contexts. First I shall discuss very quickly some of the baggage we have inherited from the past, then come back to the four areas where I see the most interesting changes.

Entrepreneurialism in health care is not new. Indeed, fee-for-service practice is itself a form of entrepreneurialism. Much of medical education in this country developed out of profit making schools, the so-called proprietary medical schools of the 19th century. The idea of the fee has been central to American medical care rather than the idea of government owned hospitals with salaried physicians, which exists in many other countries. The fee, with its assumption that medicine is something to buy and sell, is at the heart of entrepreneurialism, and embedded in the history of American medicine. One enthusiastic British critic of health services, Henry Burdett, wrote in praise of America in 1893 that America was the home of the "pay system." The American population has long been accustomed to buying medical care as if it were a commodity in the marketplace.

Eli Ginzberg has invented a catchy phrase in his recent pièce in the *New England Journal of Medicine:* the "new monetarism." My point is that the new monetarism is built on a long history of "old monetarism." We sometimes tend to stick "newness" on to relatively ancient things. Entrepreneuri-

*Ginzberg, E.: The monetarization of medical care. *N. Engl. J. Med. 310:* 1162-51, 1984.

alism and profit making behavior in general, not only in the profit making institutions, but also in the not-for-profit sector and among professions, are distinguishing characteristics of American medicine.

The concern about the role of large-scale organizations in medical care is also a continuing American theme. Debates and conflicts on the corporate practice of medicine of the 1930s and the 1940s, the exclusion by hospitals of physicians who belonged to what we now call HMOs, the strong position taken by the American Medical Association against corporate practice, arguments by the FTC as to whether medicine was a profession or a trade, all these ring oddly to our ears today, in our enthusiastic (if uneasy) commitment to corporate activity. Yet issues underlying the corporate practice debates 40 and 50 years ago need exploring once again.

The issues of corporate practice, old and new, are not only economic issues: how the professions fit into new organizational patterns of care and how they and their patients respond to different kinds of financial incentive. There also are (and were) fundamental ethical issues to consider. How does the role of the doctor and the patient change under new organizational forms of care? Is the doctor-patient relationship important in the new age of advanced communications? If we take a commodity approach to medicine as a reasonable approach to the buying and selling of health services, does the doctrine of caveat emptor take precedence over traditional notions of trust and professional responsibility? Moreover, in a commodity oriented system, why should patients pay huge bills for treatment that is not successful? And who decides on the quality of the goods? Such questions are now in the forefront of debate just as they were in the 1940s. We are looking for new guidelines around which we can build ethical behavior and new definitions of professionalism in a changing framework. An institution such as the New York Academy of Medicine should have a major role to play in such debates. Rethinking the nature of professionalism in terms of the "new entrepreneurialism" is important because of the question of conflict of interest or potential conflict of interest, where professionals make money not just from prescribing drugs or forms of diagnosis and treatment in which they have a financial interest, but in terms of ownership of facilities. Whether or not the physician is to be seen as "economically rational" in maximizing his income, and how far this perception conflicts with traditional notions of physician responsibility to the patient, are critical questions on the "new professionalism" and caveat emptor.

These questions are sometimes difficult to answer because we have in the

1980s, as before, a tendency to give lip service to very broad rhetoric which masks underlying continuity and changes. For the past decade the language of the marketplace has infused and confused health care debates. Yet apparent consensus around broad themes can be naive, misleading, and eventually dangerous. It was only in the 1960s, historically not so long ago, that we were talking about mainstream medicine—and look how quickly the pendulum swung from a commitment to equity to a commitment to efficiency. Tomorrow we may be talking about rationalization or some other catch phrase. DRGs, barely implemented, are assumed to be temporary. Today's fashion is quickly rejected.

The rhetoric is also invariably vague. We may all agree that entrepreneurialism is an issue yet we tend, if we are not careful, to take entrepreneurialism as a word, as if we all knew what we were talking about, that is, as if it meant one single set of implications or issues. Entrepreneurialism is generally associated with competition, inventiveness, and efficiency. Yet it is quite clear that in many cases competition in health care does not promote efficiency. Dr. Moore's discussion of emergency centers is a case in point. Efficiency, like quality, can have many meanings.

In the 1980s, as in the 1940s, the American medical profession is wracked by enormous external change and schisms within the profession itself. The supply of physicians is increasing, promoting self-protective behavior among established practitioners and anxiety among the younger entrants as to their appropriate professional roles. One could take a gloomy position, pointing to the difficulties in practising medicine in the late 20th century. I prefer to turn this around. A time of self-doubt is a good time to be creative. This is a good time from within medicine to look at the fundamental aspects of being a physician, which distinguish the role from that of a business operator.

If professionalism is one theme underlying the notion of entrepreneurialism, change within medicine itself is a second—and a theme that sometimes, surprisingly, gets overlooked. Important changes within medicine itself affect assumptions about entrepreneurialism as a theme. First, very little overt attention has been paid to the organizational implications of the decline of infectious diseases in the 20th century, the rise of chronic diseases, and the control of formerly socially dangerous conditions, such as tuberculosis. Public health programs were developed in the 19th and early 20th centuries because it was in the collective self-interest of the majority of the population to overcome infectious diseases and to limit potentially dangerous social conditions.

Feeding into this phenomenon has been the much more recent movement stressing individual responsibility for health. This movement is both seductive and important. However, the more one looks at the individual's responsibility for his state of health (and no one else's), the less there appears to be a rationale for a collective response for the provision of medical care. I think we will move toward more collective goals for medicine in the future, but we are still a long way from this. There is at the moment no collective ideology to provide medical care or public health—and no overriding premises as to why there should be, outside of constant debates over costs.

The increased importance of machinery and complex technologies in medicine during the last decades has emphasized the commodity approach to medical care—or image of a consumer buying a thing, a procedure, a set of tests. That, again, feeds into the ideology that resources should be allocated by the pocketbook, that consumers should shop around for best buys in a competitive system, that providers segment markets and each seek a larger market share, and that government picks up the pieces.

There are some bizarre results from changes in the nature of medicine. One is the denial of public responsibility by practitioners in health care institutions. A second is the tendency to equate medical care *value* with its *price,* irrespective of whether the patient benefits.

The administration recently suggested that the level of poverty in the United States take into account not only cash benefits but benefits in kind, with one of the benefits in kind being Medicaid. That is bizarre. Are we going to say that somebody who is a patient in a hospital receiving very expensive treatment is relatively rich? This is obviously nonsense, but it may be logical in terms of the commodity approach to medicine. Such comments are not purely issues of entrepreneurialism, but they are historically important when we look at much broader changes in medicine over this century.

My third point, about investor-ownership, I shall touch on only briefly because both Drs. Moore and Schramm have dealt with this already. I do want to stress the role of investors as absentee landlords. In some senses, medical care may go the way of agriculture, toward agribusiness, the demise of the family farm, the removal of ownership from the local area, and sometimes the creation of problems because of lack of local interest in or information about local conditions. Is medicine going to become medibusiness? In some respects, this process is well underway. Witness absentee landlords in investor-owned chains. We may also see decision-making increasingly removed from local communities because of the rise of not-for-profit

conglomerates and chains. Over and above incentives by investors for the system to generate revenues, issues relating to absentee landlords deserve fuller consideration than they have yet received.

My final point about change concerns the rise of fourth parties. New groups appear on the scene with increasing power, groups which are not, strictly, doctors, patients, or payers, particularly groups of investors, business coalitions, major purchasers of insurance, and self-help groups. The management of fringe benefits is an increasingly important force. At this stage it is impossible to predict the full impact of these new entrants. However, one insidious thread in the fourth parties is this reinvention in many cases of local as well as national interests. The local role of business coalitions and major purchasers of insurance, in particular, needs to be balanced against the countervailing tendencies of absentee landlordship. In the long run, the rise of fourth parties may prove to be the "sleeper" of entrepreneurialism.

Historical perspective finds no juggernaut of entrepreneurialism sweeping over us all as helpless victims. America is a practical, flexible society. New interests arise. Entrepreneurialism is a useful way for looking at change in the 1980s, provided it is realized that the changes now taking place can only partly be dealt with under the umbrella of this rhetoric. As health professionals we need to look at the public nature of our professions. We need to consider the development of collective ideals for health care in the United States. Indeed, down the road, maybe five or 10 years from now, we shall see the rediscovery of inequities in the health care system. I think we are going to see, in addition, a constant jockeying, locally, between absentee decision-making in major health care firms and local control, a process in which fourth parties are going to be increasingly visible.

It is impossible to predict the exact shape of medical care 20 or 30 years from now. If we hopped back now to 1965 we could not possibly predict the various changes that would arise by 1984 under the impact of Medicare and Medicaid. But we were asked on this panel to ask, "Who will benefit?" In fact we use prediction as an art form here and in other fora to reflect upon and to affect the present. There is no reason why we should not all benefit from recent changes in the health care system. To do so, we need to consider the more general themes and to focus on concepts of value for money rather than concepts of price in medicine. We are engaged today not so much in a critique of entrepreneurialism as in a continuing historical process of definition and consensus-building.